

Appendix 2

If my childhood memory serves me right, I believe that my grandfather, John W. Baker, was diagnosed as having cancer of the liver. Then by some miracle we thought, his cancer went away, without treatment. His death was recorded a short time later as heart failure, as I recall. As an adult today in Libby, I question all this, knowing that my grandfather worked for Zonolite & Co.

Since our enlightenment in the past three and a half years, I learned that my uncle Morland Baker, uncle Morley, died from mesothelioma, he worked for Zonolite for two years. He died as a fairly young man.

My dad died at age 64 after having to tote an oxygen bottle around everywhere he went. He had asbestosis and probably lung cancer, his heart stopped too. He worked for Zonolite Co. and W.R. Grace off and on over the years. My mother endured cancer treatment and dialysis for the last ten years of her life, she got to wash a miner's clothes. My six siblings and myself were all exposed as children and show clinical signs of exposure.

As we increase in age, so increases our risk of developing mesothelioma and we wonder how long before our pleural thickening turns to full blown lung dysfunction.

As we wait for the EPA risk assessment, we acknowledge that our fiber is of the amphibole family, which contains a fiber type "crocidolite" known to be 500 times more mesothelioma potent than the commercial type fiber "chrysotile"-- not ten times, not fifty times, that is, 500 times more disease potent. It is expected that our fiber is really ugly stuff. We see with our eyes what it does to our people; we see what the science says, really ugly stuff, this mineral fiber that we've been subjected to.

My brother recently underwent surgical treatment for a cancer, successfully we pray; a cancer so rare that there are only 400 cases in America, recorded per year. Was this cancer a result of his childhood exposure?

Asbestos fibers have been recovered from almost every tissue in the human body, given that the scientists got it right, a known complete carcinogen.

We have 1,500 people out 6,500 x-rayed showing pleural abnormalities on x-ray. We know that 85 to 90% of pleural plaques will be missed when only x-ray is used as the detection tool. We know that 80% of people who develop mesothelioma do not also have an accompanying diagnosis of "asbestosis". Meaning that an exposed person is at risk of developing mesothelioma even if there are no clinical signs of exposure. We know that a threshold level of exposure below which mesothelioma will not occur has not yet been identified. We don't know how little of exposure it takes to produce this incurable cancer. We also know that these fibers are bio-persistent and exposures are accumulative. Extremely low level exposures, when repeated, in time add up to the equivalent of a high exposure and there is evidence that at least low level, episodic exposures, continue in Libby.

We want the exposures to stop as soon as possible! HEPA vacuums need to be distributed in Libby today, when the risk of exposure is the greatest, not after the cleanup is finished. There is no funding, but common sense and need--says that there should be. Jim Christensen didn't get all the funding he requested, so therefore, household exposures will continue -- needlessly.

The question is: will we proceed forward addressing these issues, utilizing the science, incorporating common sense, acknowledging the need and what is right; or do we proceed with the idea that politics and money should dictate our outcome.

Last I heard, we have over 400 people who live here, trained and ready to go to work on our cleanup. We have a huge amount of work that needs to be done, and done thoroughly. Libby Montana needs that clean bill of health as soon as possible; the future of our town is dependent upon the thoroughness of the cleanup and that date of completion. So, rather than talk of making due with less resources, I would suggest that we discuss increasing the funding here to address the need.

We are way tired of the exposure!! To deny adequate funding is to deny us of our rights as American Citizens.

Appendix 3

From: Kimberly Rowse
Sent: Thursday, October 16, 2003 4:04 PM
To: Gerald Mueller
Cc: Brad Black, Sandy Wagner, and Pat Chan.
Subject: ARD/WR Grace Patients at the LCCHC

Thank you for the opportunity to address the CAG and community regarding services and resources at the Lincoln County Community Health Center (LCCHC). I was asked several questions that I would like to address. Please forward to the CAG members at your next meeting.

#1. How many ARD (asbestos-related disease) patients does the LCCHC serve?

ANSWER: *This is a difficult question secondary to the way the providers code diagnosis. We show that LCCHC serves 26 patients with the primary diagnosis of asbestosis. We may see other asbestos patients yet they maybe seen for other medical problems and ARD may not be identified as their primary diagnosis.*

#2. How many patients does the LCCHC serve on the WR Grace plan?

ANSWER: *LCCHC has 37 WR Grace Accounts to date.*

#3. How many ARD patients have been turned to collection?

ANSWER: *We have worked with one individual in the ARD group to assist them in keeping their account current. No ARD patient from LCCHC has been sent to collections. Our collection policy includes 3 statements (30 day, 60 day, 90 day) a letter @ 90 days requesting contact and/or payment to keep account current is included with statement. LCCHC accepts ANY amount on a regular monthly basis to show activity and intent for payment. If no contact or payment is received after the account is 125 days old and after review, only then is it placed with a collection agency. We make courtesy phone calls @ 90 days including a letter and make every attempt to work with the individual to keep account current. Any aged account of 120 days old and are less than twenty dollars(\$20) shall be written-off as bad debt.*

I hope that this Information Is useful in assisting ARD patients and the community to understand the mission of the LCCHC is to provide access to primary health services. NO ONE IS REFUSED SERVICE ON THEIR ABILITY TO PAY. Please forward this information onto those that requested and if I can be of further resource, please feel free to call. Thank you for your dedication and efforts facilitating this group.

Appendix 4



Health Network America

Benefit from the difference

- *Benefits Administration*
- *Health Plan Consulting*
- *Health Information Systems*

November 12, 2003

Libby Area Community Advisory Group

Dear Members:

Health Network America (HNA) has been asked to respond to your letter dated October 9, 2003 expressing concerns regarding the payment of medical and pharmaceutical claims by the Libby Medical Plan (LMP). As many of you know, HNA administers the LMP and part of its responsibilities is paying members' medical claims (bills). When paying such claims, HNA has one goal in mind, to provide the best care at a fair price for LMP members, with no balance billing to plan members. Achieving this goal often requires negotiations between HNA and various health service providers. This process is ongoing, and can change as new issues arise. Some of these new issues, as well as other concerns, are raised in your letter. They include: payment for prescription drugs; payment of outpatient services (e.g. visits to a doctor's office); and payment for in-patient hospital expenses. Each is dealt with separately below.

1. Pharmacy. The pharmacy benefit of the LMP is administered by Medco Health. They have 58,000 pharmacies in their network throughout the United States. There are numerous participating pharmacies in your area, including:

- Libby
 - Libby Drugs
 - Rosaurers
 - Frank's Express Drugs
 - Center Drugs
- Troy
 - Kootenai Drugs
- Eureka
 - Haines Drugs

When a member of the LMP fills a covered prescription at a participating pharmacy, there should be no co-pays or balance billing. 100% of the prescription costs are covered. While such assurances cannot be provided if a prescription is filled at a non-participating pharmacy, this is because the LMP, in that case, has no control over what charges such a pharmacy may make for its medications. If any LMP member has any difficulty locating a participating pharmacy, they should contact Vi Kauffman, RN or Marguerite Pettinato, LPN at 1-800-332-7772.

2. Out-patient services. The LMP, like most medical plans including Medicare, makes payments based on "reasonable and customary charges." The idea behind reasonable and customary is simple, for any medical plan to remain financially viable, there must be some check on the amounts charged by participating providers. Otherwise, providers could charge whatever they wanted for services, even when other qualified and competent providers are offering the same services at a much more appropriate cost. In the LMP, claims for outpatient services and procedures are paid at 100% of the reasonable and customary amount. Usual and customary fees are determined using Health Insurance Association (HIAA) and Medical Data Research (MDR) fee schedules that are generated each year by these companies. HNA uses the most up to date schedules these companies provide. These fee schedules, along with Medicare fees, are the standards for health plan fee schedules in the United States. In most instances this amount will be the same as the charge, however if the charge is excessive, then the reasonable and customary payment will be less than the charge.

Under the reasonable and customary payment system, there is always a chance that the medical provider will balance bill the member for the difference between the amounts they originally charged and the reasonable and

customary payment made. Most providers do not do this, and HNA is unaware of this ever occurring in the LMP. If any LMP member experiences a problem with balance billing for outpatient services, they should contact Vi or Marguerite.

3. In-patient services. In the case of in-patient services, fee schedules to establish reasonable and customary payments do not exist, making the payment process more complicated. As a result, a system has developed where hospitals generally belong to networks, which establish appropriate reimbursement rates. In the case of the Libby Medical Program, with one exception, all of the hospitals its member were admitted to in 2002 and 2003 such as St. Patrick's Missoula, MT, Deaconess Spokane, WA, and Kalispell Regional Medical Center were part of the Multiplan network. HNA uses Multiplan so that the reimbursement to the hospital is established and the hospital agrees not to balance bill the members. HNA is not aware of any members of the Libby Medical Program who were balanced billed by Multiplan hospitals, and asks to be notified if this has occurred.

The only hospital members of the Libby Medical Program were admitted to in 2002 and 2003 that does not participate in Multiplan is St. John's Lutheran Hospital (SJLH). HNA has been reimbursing SJLH 80% of their charges, which we believed to be reasonable and appropriate for the services provided. Although we are not aware of any balance billing occurring from SJLH to members of the LMP, they do have the right to do so. To remove this as an issue of concern for LMP members, HNA has decided to access the Beech Street network, a national network present in almost all states. SJLH already has a contract to participate in Beech Street and HNA will enroll the LMP in the Beech Street. This arrangement will allow SJLH to be fairly reimbursed for its services to members of the LMP, without any balance billing to the members.

Thank you for your interest in the Libby Medical Plan and the services it provides to its members. Please contact HNA directly if you have any additional questions.

Sincerely yours,

Stephen A. Kardos DO
Chief Executive Officer
HNA

J. Jay Flynn MD
Chief Medical Officer
HNA

Vi Kauffman RN
Nurse Advocate
HNA

Appendix 5
Draft

November 10, 2003

Mr. Mike McGrath
Attorney General
State of Montana
Helena. MT 59620

Dear Mr. McGrath:

We, the Libby Community Advisory Group, have been pursuing the law within Superfund legislation (CLRCLA) 9604 (i) (l) (D) as an avenue that might address our long term health care issue resulting from our toxic exposure. It is our layman's interpretation of this law that the federal government created this law and the Agency for Toxic Substances and Disease Registry (ATSDR) to address the event that toxic exposure to a population had occurred. Our recent petition to Secretary Tommy Thompson dated. May 8, 2003, requesting a Declaration of Public Health Emergency be made for Libby, was responded to by the Administrator of CDC-ATSDR, Dr Louise Gerberding, with denial of such a declaration. As you will see from the enclosed correspondences, our interpretation is vastly different from Ms Gerberding's. The question is in your opinion, does this law provide for health care for those subjected to long latency disease?

The long term medical needs of this exposed population are beyond the means of all but the wealthy, the Grace medical plan is inadequate and unsecure. It seems that in our future lies the prospect that this toxic trespass will be completely shouldered by the exposed.

Enclosed you will find copies of the letters of correspondence relating to this issue.

We greatly need and appreciate whatever help that you might extend our way.

Sincerely and with many thanks,

Libby Community Advisory Group